

Child's Name \_\_\_\_\_

## Camp Prov 2021 Camper Registration Form

→ (EACH child must have a separate form) ←  
- Please Write Neatly! -

**The full tuition of Camp Prov is \$110, which is a small percentage of the actual cost. Due to needing to restrict numbers of campers we will need to limit the ages of Campers this year. We will be accepting children ages 4-9, and siblings ages 4-7.**

|                              |             |                |                   |
|------------------------------|-------------|----------------|-------------------|
| Child's Name<br><b>First</b> | <b>Last</b> | Date of Birth: | Age on<br>7/1/21: |
|------------------------------|-------------|----------------|-------------------|

|                        |                                   |
|------------------------|-----------------------------------|
| Name Child<br>Goes By: | Siblings<br>at Camp (First Last): |
|------------------------|-----------------------------------|

|                       |                   |
|-----------------------|-------------------|
| Child's<br>Diagnosis: | Primary Language: |
|-----------------------|-------------------|

|                    |                    |
|--------------------|--------------------|
| Street<br>Address: | City,<br>Zip Code: |
|--------------------|--------------------|

|  |               |
|--|---------------|
| Parent/Legal<br>Guardian (First Last): | Relationship: |
|--|---------------|

|                          |        |
|--------------------------|--------|
| Primary Phone<br>Number: | Email: |
|--------------------------|--------|

**Please indicate which week & session you prefer by numbering your choices 1-4**  
**Sessions are filled on a first come, first served basis**

|              |                                   |                                  |
|--------------|-----------------------------------|----------------------------------|
| July 12-16:  | 9am-12pm <input type="checkbox"/> | 1pm-4pm <input type="checkbox"/> |
| July 19-23:  | 9am-12pm <input type="checkbox"/> | 1pm-4pm <input type="checkbox"/> |
| July 26-30:  | 9am-12pm <input type="checkbox"/> | 1pm-4pm <input type="checkbox"/> |
| August 2-6:  | 9am-12pm <input type="checkbox"/> | 1pm-4pm <input type="checkbox"/> |
| August 9-13: | 9am-12pm <input type="checkbox"/> | 1pm-4pm <input type="checkbox"/> |

**Child's T-shirt size:**  X-Small  Small  Med.  Large  X-Large

**Completed Forms can be mailed to:**  
Providence Children's Center Camp Prov  
900 Pacific Ave Suite 130, Everett WA 98201  
-or-  
FAXED to 425.258.7618

**Please make checks/money orders payable to:**  
Children's Center - Camp Prov  
**Note:** We accept checks, credit / debit cards, but  
are unable to accept cash

Child's Name \_\_\_\_\_

***Please Note: We are here to support your child the best way we can during their time at Camp Prov!***

**Tell us about your child**

**What are his or her strengths and abilities?**

**What are his or her favorite toys and things to do?**

**What makes him or her a great kid?**

**What makes your child feel proud of them self?**

**Current Services**

Does your child receive services at Providence Children's Center?

Yes       No

**Hearing & Vision**

How does your child hear and see?

- Typical Hearing       Hearing loss  
 Wears hearing aid/s       Cochlear Implant  
 Other \_\_\_\_\_  
 Vision loss       Wears glasses       Uses a cane  
 Other \_\_\_\_\_

**Communication**

How does your child communicate?

- Spoken words -- understandable to others?       Yes       No  
 Sounds       Signs       Gestures       Communication board, PECS  
 Augmentative Communication Device: \_\_\_\_\_  
 Sign Language  
 Other: \_\_\_\_\_

***If your child has a communication device, please plan on bringing it labeled with their name to camp and allow time on the first day to review with staff.***

How will your child tell us he/she is:

Having a good time \_\_\_\_\_

Is sick or in pain \_\_\_\_\_

Anything else we should know about your child's **Communication**? \_\_\_\_\_

Child's Name \_\_\_\_\_

**Swimming- NOTE: The swimming pool is closed**

It is OK for my child to get wet in the waterpark:  Yes  No

**Likes and Dislikes**

My child tends **enjoy** the following:

- Tight spaces  Brushing  Squeezing  Jumping  
 Heavy lifting/carrying  Swinging  Spinning  
 Other: \_\_\_\_\_

My child tends to **avoid** the following:

- Bath time/pool  Loud noises  Friend / Peer interaction  
 Large groups  Food  Certain smells  Animals  
 Sitting at a table  Getting hands dirty  
 Other: \_\_\_\_\_

**Behavior**

Does your child have a behavior plan? (if yes, please attach it or a summary so we can follow it also)

- Yes  No

What should we know about your child's behaviors? (such as going from one activity to another)

*If your child has a comfort toy/object, please send it labeled with name in the child's backpack in the event we need it to help soothe.*

What do you do to calm and reassure your child?

Does your child: (check all that apply)

- Run away  Hit  Kick  Spit  
 Bite/scratch/pinch / hit themselves  Bite/scratch/pinch others  
 Other: \_\_\_\_\_

**Child's Name** \_\_\_\_\_

**Social and Home**

What does your child typically enjoy doing:

- playing with a friend     playing with several friends     playing by themselves
  - reading     drawing / painting / crafts     building (like Legos)
  - playing video games alone     playing video games with friends
  - team sports (soccer, football)     individual sports
  - prefers to be outdoors     prefers to be indoors
  - Other \_\_\_\_\_
- 

When separating, what works for you and your child?

- needs some encouragement but otherwise separates well
  - some crying, needs reassurance, sometimes distraction
  - My child has never been separated from me or family
  - Other \_\_\_\_\_
- 

**Mobility**

How does your child move around?

- Walks
- Crawls
- Uses walker, crutches or cane(s)
- Uses Wheelchair                       Other: \_\_\_\_\_

Anything else we should know about your child's **mobility**?

**Toileting**

My child:

- Needs no help or reminders to go to the bathroom
- Wears a diaper
- Needs prompting to go to bathroom

How often: \_\_\_\_\_

What do you say to prompt: \_\_\_\_\_

How I know my child needs to use the bathroom: \_\_\_\_\_

Help my child needs when toileting

- None
- Clothing management
- Wiping / hygiene

**Child's Name** \_\_\_\_\_

**Comfort/Security**

We call parents when there is a serious medical issue. Are there any other reasons you would want us to call you?

(examples: Inconsolable or crying for a long period of time)

**Emergency Contacts**

1) Name: \_\_\_\_\_ Phone \_\_\_\_\_

2) Name: \_\_\_\_\_ Phone \_\_\_\_\_

***For safety reasons, you or your designated caretaker may be required to provide a password upon picking your child up from Camp.***

***Your family's password will be:*** \_\_\_\_\_

**Child's Health History**

Current height: \_\_\_\_\_ Weight: \_\_\_\_\_

Check if you child has any of the following conditions:

- |   |  |
|---|--|
| <input type="checkbox"/> Infections   | <input type="checkbox"/> Asthma, Bronchiolitis           |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Allergies (other than to drugs) |
| <input type="checkbox"/> Seizures/Convulsions (see below)   | <input type="checkbox"/> Respiratory/Breathing Problems  |
| <input type="checkbox"/> Stomach or intestinal issues   | <input type="checkbox"/> High/Low Blood Pressure         |
| <input type="checkbox"/> Urinary/Kidney difficulties  |  |
| <input type="checkbox"/> Sensitivities to: <input type="checkbox"/> sun <input type="checkbox"/> chlorine <input type="checkbox"/> sunscreens |  |

***If you checked any of the above, please give details:*** \_\_\_\_\_

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**Dietary**

Does your child have any of these feeding or dietary concerns? (note: Camp Prov is nut-free and gluten free for our campers!)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Gluten free        | <input type="checkbox"/> Casein free         |   |
| <input type="checkbox"/> feeding tube       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Swallowing/choking |
| <input type="checkbox"/> Nut allergy        | <input type="checkbox"/> Lactose intolerance |   |
| <input type="checkbox"/> Other food allergy | _____  |   |

Child's Name \_\_\_\_\_

**Medical Information**

Does your child take medications?  Yes  No

If yes\*, please list:

| <u>Name:</u> | <u>Dosage</u> | <u>Frequency</u> |
|--------------|---------------|------------------|
| _____        | _____         | _____            |
| _____        | _____         | _____            |
| _____        | _____         | _____            |

**\*Please Note: Camp staff will NOT be able to administer medications except in life-threatening emergency.**

**List any medication allergies and their reactions**

\_\_\_\_\_

\_\_\_\_\_

Any significant allergies that require EpiPen (or similar) left with RN while at camp

Yes  No

**Seizure Information**

If your child has seizures, please explain:

Frequency: \_\_\_\_\_ Length: \_\_\_\_\_

Date of most recent seizure: \_\_\_\_\_

Triggers: \_\_\_\_\_

What do the seizures look like (head bobbing, eyes roll back, blank stare, etc.)?:

\_\_\_\_\_

What should be our plan of care be if your child has a seizure while at Camp (Our typical response would be to call 911 immediately)

I will leave my child's emergency medications with RN all week

Yes  No

It is OK for my child to use the Sunscreen at Camp  Yes  No

Any other medical issues information you would like to report? (e.g. overheat easily, recent hospitalization, surgery, medical equipment etc.)

\_\_\_\_\_

\_\_\_\_\_

Child's Name \_\_\_\_\_

**Please Note:** We cannot be responsible for any lost items at Camp. We highly recommend labeling all items brought to Camp with Sharpie pen or similar.

**Checklist:**

- **Please sign and return this application with:**
  - **copy of your child's immunization records (or declination of immunization)**
  - **Signed (attached) photo release (optional)**
  - **Provide payment per Payment Options (next page)**

**Send all of the above to:**

Providence Children's Center Camp Prov  
900 Pacific Ave Suite 130, Everett WA 98201

-or-

FAXED to 425.258.7618

Due to the insecure nature of email, we would prefer you did not email forms to us.

**Release/Permission**

I verify that the above medical/health information on my child is complete and accurate. I also understand that all reasonable measures will be taken to safeguard the health and safety of all participants and I will be notified as soon as possible in the case of emergency affecting my child. In the event that I cannot be reached in an emergency, I hereby authorize you and a physician to render all services and treatment deemed necessary at my expense.

**Parent / Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Continued next page**

**Child's Name** \_\_\_\_\_

**Payment Options (please check)**

- \$110 for the full tuition
- \$20 initial payment, with the remaining \$90 due by 6/25/21
- My Child is DDA respite eligible, and am planning on using my child's hours for Camp Prov.

My Child's DDA number **WA**

My Child's DDA Caseworkers Name \_\_\_\_\_

My Child's Caseworker's phone \_\_\_\_\_

My Child's Caseworker's email \_\_\_\_\_

DDA office location \_\_\_\_\_

If you are interested in **financial aid** please check here and we will contact you. **No payment due at this time.**

I would like information on sponsoring a child in need for Camp Prov

Payment enclosed  Check  
 Visa  Mastercard  AMEX  Discover

Amount \_\_\_\_\_

Name on card \_\_\_\_\_

Number \_\_\_\_\_ EXP date \_\_\_\_\_

Zip Code associated with card \_\_\_\_\_

C.V.V. number \_\_\_\_\_



Signature authorizing credit / debit card



Child's Name \_\_\_\_\_

DO NOT WRITE OUTSIDE BORDER AREA

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING AND COMMUNICATIONS**



1. I authorize Providence Health & Services to 1) interview, 2) photograph, and/or 3) videotape me and to use the interview(s), photograph(s), or videotape(s) in connection with marketing, public relations and other news media purposes which include but may not be limited to electronic or print media, brochures and other printed materials, displays, and/or radio and television. If the intended use is not included above, please indicate:

Other Use: \_\_\_\_\_

Name: (please print) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

- 2. I understand that I have the right to request cessation of recording or filming, or interviewing.
- 3. I understand that the information used or disclosed pursuant to this authorization is not covered by federal privacy regulations, and that any health information disclosed may be re-disclosed and is no longer protected under federal law.
- 4. I understand that this authorization is for the uses listed above. The use of these materials for archival or historical purposes is part of PH&S operations and is not encompassed in this authorization.
- 5. I understand that I do not need to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.
- 6. This authorization only applies to information created within 90 days from the date of this authorization. I understand that Providence Health & Services may use this information at any time up to five years from the date signed, or upon revocation, whichever occurs first. PH&S will honor my revocation to the extent this authorization has not been relied on for the creation and distribution of materials that include my information. To revoke this authorization, I must send a written statement, including my full name, address and phone number stating that I am revoking this authorization to:

*Marketing and Communications  
Providence Regional Medical Center Everett  
PO Box 1147, Everett WA 98206*

7. I have read this authorization and I understand it, and affirm that I have reached the age of legal majority (18) according to the laws of Washington State. By:

\_\_\_\_\_  
INDIVIDUAL/PERSONAL REPRESENTATIVE Date: \_\_\_\_\_

Personal Representative's Name (please print): \_\_\_\_\_

Description of personal representative's authority: \_\_\_\_\_

**For official Providence use only.**

Name and title of PH&S employee arranging authorization: \_\_\_\_\_

Description of interview, photograph and/or videotape: \_\_\_\_\_

WHITE COPY: MEDICAL RECORD      YELLOW COPY: MARKETING AND COMMUNICATION      PINK COPY: PATIENT



Colby Campus • 1321 Colby Ave.  
Pacific Campus • 916 Pacific Ave.  
Pavilion for Women and Children  
900 Pacific Ave. • Everett, WA 98206

**AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION FOR MARKETING AND COMMUNICATIONS (08/09)**

#31591 (09/21/09) - D

Align Patient Sticker Here

Child's Name \_\_\_\_\_

We require proof of immunization or exemption. Below are samples of The Certificate of Immunization like below or from your medical provider's office and the Exemption form. Certificate used must be signed by the provider.

**Certificate of Immunization Status (CIS)**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Signed COE on File?  Yes  No

Please print. See back for instructions on how to fill out this form or get it printed from the Washington State Immunization Information System.

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Birthdate (MM/DD/YYYY): \_\_\_\_\_

I give permission to my child's school/child care to add immunization information into the Immunization Information System to maintain my child's record. Conditional Status Only: I acknowledge that my child is entering school/child care in conditional status. For my child to remain in school, I must provide required documentation of immunization by established deadlines. See back for guidance on conditional status.

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_  Parent/Guardian Signature Required if Starting in Conditional Status \_\_\_\_\_ Date: \_\_\_\_\_

**Documentation of Disease Immunity (Health care provider use only)**

If the child named in this CIS has a history of varicella (chickenpox) disease or can show immunity by blood test (titer), it must be verified by a health care provider.

I certify that the child named on this CIS has:

- A verified history of varicella (chickenpox) disease.
- Laboratory evidence of immunity (titer) to disease(s) marked below.

Diphtheria  Hepatitis A  Hepatitis B  
 Hib  Measles  Mumps  
 Rubella  Tetanus  Varicella  
 Polio (all 3 serotypes must show immunity)

**Recommended Vaccines (Not Required for School or Child Care)**

Flu (Influenza)  
 Hepatitis A  
 HPV (Human Papillomavirus)  
 MCV/MPSV (Menigeococcal Disease types A, C, W, Y)  
 MenB (Menigeococcal Disease type B)  
 Rotavirus

I certify that the information provided on this form is correct and verifiable. Health Care Provider or School Official Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 If verified by school or child care staff the medical immunization records must be attached to this document.

**Certificate of Exemption—Medical**

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Birthdate (MM/DD/YYYY): \_\_\_\_\_

**NOTICE:** This form may be used to exempt a child from the requirement of vaccination when a health care practitioner has determined specific vaccination is not advisable for the child for medical reasons. This form must be completed by a health care practitioner and signed by the parent/guardian. An exempted child/student may be excluded from school or child care during an outbreak of the disease they have not been fully vaccinated against. Vaccine-preventable diseases still exist, and can spread quickly in school and child care settings.

**Medical Exemption**

A health care practitioner may grant a medical exemption to a vaccine required by rule of the Washington State Board of Health only if in their judgment, the vaccine is not advisable for the child. When it is determined that this particular vaccine is no longer contraindicated, the child will be required to have the vaccine (RCW 29A.210.090). Providers can find guidance on medical exemptions by reviewing Advisory Committee on Immunization Practices (ACIP) recommendations via the Centers for Disease Control and Prevention publication, "Guidance for Vaccine Providers on Contraindications and Precautions," or the manufacturer's package insert. The ACIP guide can be found at: [www.cdc.gov/vaccines/imz/downloads/pdf/13w0101.pdf](http://www.cdc.gov/vaccines/imz/downloads/pdf/13w0101.pdf)

Please indicate which exemption is referring to by disease. If the patient is not exempt from certain vaccines, check the appropriate box.

| Disease      | Not Exempt               | Temporary Exempt         | Expiration Date for Temporary Medical |
|--------------|--------------------------|--------------------------|---------------------------------------|
| Diphtheria   | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Hepatitis B  | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Hib          | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Measles      | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Mumps        | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Pertussis    | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Pneumococcal | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Polio        | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Rubella      | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Tetanus      | <input type="checkbox"/> | <input type="checkbox"/> |                                       |
| Varicella    | <input type="checkbox"/> | <input type="checkbox"/> |                                       |

**Health Care Practitioner Declaration**

I declare that vaccination for the disease(s) checked above is/are not advisable for this child. I have discussed the benefits and risks of immunizations with the parent/legal guardian as a condition for exempting their child. I am a qualified MD, ND, DO, ARNP or PA licensed in Washington State, and the information provided on this form is complete and correct.

Licensed Health Care Practitioner Name (print) \_\_\_\_\_ Licensed Health Care Practitioner Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 MD  ND  DO  ARNP  PA Washington License # \_\_\_\_\_

**Parent/Guardian Declaration**

I have discussed the benefits and risks of immunizations with the health care practitioner granting this medical exemption. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

Parent/Guardian Name (print) \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711). DOH-348-106 October 2019

**Certificate of Exemption—Personal/Religious**

For School, Child Care, and Preschool Immunization Requirements

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Birthdate (MM/DD/YYYY): \_\_\_\_\_

**NOTICE:** A parent or guardian may exempt their child from the vaccinations listed below by submitting this completed form to the child's school and/or child care. A person who has been exempted from a vaccination is considered at risk for the disease or diseases for which the vaccination offers protection. An exempted child/student may be excluded from school or child care settings and activities during an outbreak of the disease that they have not been fully vaccinated against. Vaccine-preventable diseases still exist, and can spread quickly in school and child care settings. Immunization is one of the best ways to protect people from getting and spreading diseases that may result in serious illness, disability, or death.

**Personal/Philosophical or Religious Exemption**

I am exempting my child from the requirement my child be vaccinated against the following disease(s) to attend school or child care. (Select an exemption type and the vaccinations you wish to exempt your child from:)

**PERSONAL/PHILOSOPHICAL EXEMPTION\***

Diphtheria  Hepatitis B  Hib  Pneumococcal  
 Polio  Pertussis (whooping cough)  Tetanus  Varicella (chickenpox)  
 \*Measles, mumps, or rubella are not exempted for personal/philosophical reasons per state law.

**RELIGIOUS EXEMPTION**

Diphtheria  Hib  Pneumococcal  
 Polio  Pertussis (whooping cough)  Tetanus  Varicella (chickenpox)  
 Measles  Rubella

**Parent/Guardian Declaration**

One or more of the required vaccinations for my child is/are not consistent with my philosophical, or religious beliefs. I have discussed the benefits and risks of immunizations with the health care practitioner. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

Parent/Guardian Name (print) \_\_\_\_\_ Date: \_\_\_\_\_

**Health Care Practitioner Declaration**

I have discussed the benefits and risks of immunizations with the parent/legal guardian for exempting their child. I am a qualified MD, ND, DO, ARNP, or PA licensed in Washington State.

Licensed Health Care Practitioner Name (print) \_\_\_\_\_ Licensed Health Care Practitioner Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 MD  ND  DO  ARNP  PA Washington License # \_\_\_\_\_

**RELIGIOUS MEMBERSHIP EXEMPTION**

Complete this section ONLY if you belong to a church or religion that objects to the use of medical treatment. Use the section above if you have a religious objection to vaccinations but the beliefs or teachings of your church or religion do not prevent your child to be treated by medical professionals such as doctors and nurses.

**Parent/Guardian Declaration**

I am the parent or legal guardian of the above-named child. I affirm I am a member of a church or religion whose teaching does not allow health care practitioners to give medical treatment to my child. I have been told if an outbreak of vaccine-preventable disease occurs for which my child is exempted, my child may be excluded from their school or child care for the duration of the outbreak. The information on this form is complete and correct.

Parent/Guardian Name (print) \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

If you have a disability and need this form in a different format please call 1-800-525-0127 (TDD/TTY Call 711). DOH-348-106 October 2019